

FILED DEC 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43292**
Registrar's No. **179**

BIRTH NO.		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 179	
1. PLACE OF DEATH a. COUNTY SCOTT				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY SCOTT			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SIKESTON		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SIKESTON		d. STREET ADDRESS (If rural, give location) 212 N. PRARIE	
d. FULL NAME OF HOSPITAL OR INSTITUTION 212 N. PRARIE							
3. NAME OF DECEASED (Type or Print) a. (First) LILLIAN b. (Middle) HELEN c. (Last) McCOY				4. DATE OF DEATH (Month) (Day) (Year) 12 - 4 - 1950			
5. SEX 7 1 WHITE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH 7-2-1904	
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) BUTLER Co Mo O	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME THOMAS A GOINS		13b. MOTHER'S MAIDEN NAME NANCY JANE KNOX		14. NAME OF HUSBAND OR WIFE Mrs. J. A. Stokers, Lebanon, Mo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Mrs. J. A. Stokers, Lebanon, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inflammatory Carcinoma, left breast ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 months	
19a. DATE OF OPERATION 11-29-50		19b. MAJOR FINDINGS OF OPERATION Diagnosis: Medullary Carcinoma Biopsy: Missouri Delta Community Hospital				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-31, 1950 , to 12-4, 1950 , that I last saw the deceased alive on 12-4, 1950 , and that death occurred at 10:50 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE Mary J. Ingram, M.D.		(Degree or title)		23b. ADDRESS SiKESTON, Mo.		23c. DATE SIGNED 12-12-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 12-6-50		24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		24d. LOCATION (City, town, or county) (State) SIKESTON Mo.	
DATE REC'D BY LOCAL REG. 12-12-50		REGISTRAR'S SIGNATURE Mrs. Ella Hentges		25. FUNERAL DIRECTOR'S SIGNATURE Welch Funeral Home - SiKESTON Mo		ADDRESS	

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SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 1250-18

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Raymond Lewis

Licensed Embalmer No. 3467

P. O. Address Sekeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.